| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 003930 | A. BUILDING: _____ B. WING _____ | 12/29/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| INDIANA ORTHOPAEDIC HOSPITAL | 8400 NORTHWEST BLVD INDIANAPOLIS, IN 46278 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This visit was for the investigation of one (1) State complaint.<br><br>Complaint Number: IN00146010<br>Unsubstantiated; Lack of Sufficient Evidence<br><br>Date of survey: 12/29/14<br><br>Facility number: 003930<br><br>Surveyors:<br>Jennifer Hembree RN<br>Public Health Nurse Surveyor<br><br>Marcia Anness RN<br>Public Health Nurse Surveyor<br><br>Indiana Orthopaedic Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules.<br><br>QA: claughlin 01/02/15 | S 000 | | |